WHITE PAPER

Get the right reimbursement for high risk patients

A proven strategy for managing Hierarchical Condition Categories (HCCs) in your EHR

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Overview

Medicare Advantage (MA), an alternative to traditional Medicare, has tripled in size over the last decade. With over 20 million people enrolled, MA patients comprised 34% of all Medicare beneficiaries in 2018, and estimates indicate that by 2022, the number of enrollees will reach 22 million. MA programs contract with the Centers for Medicare and Medicaid Services (CMS) to administer health benefits to their members. CMS payments to MA plans use a prospective, risk-adjusted model to reflect the healthcare expenditures of members based on both their demographics and their overall health risk. This risk-adjusted model is then used to determine provider reimbursement.

The use of Hierarchical Condition Category (HCC) codes is critical for provider reimbursement under the MA program. HCC payments are risk-adjusted based on patient complexity, allowing for increased payments for high-risk patients. Accurate HCC coding information helps create a more complete picture of a patient population, improves the value of individual patient problem lists, and enables better management of chronic diseases.

The HCC model has expanded to assist with reimbursement for both Accountable Care Organizations (ACOs) and other shared savings programs. Therefore, as reimbursement models continue to evolve, it is increasingly important for health systems to have an effective HCC strategy. Specifically, it is vital that this strategy include consideration of how patient diagnoses are captured and documented at the point of care.

The case study below demonstrates the return on investment to a large physician group following the implementation of an effective HCC strategy. This success story illustrates the importance of integrating tools that assist in the identification, capture, and documentation of high-risk patients. By using these EHR tools, all areas of the strategy are supported, leading to an increase in HCC capture and Risk Adjustment Factors (RAF). This in turn ensures appropriate reimbursement is issued for the care delivered.

Physicians, of course, play a key role in HCC capture and reimbursement through accurate documentation of the patient's health status in the EHR. The case examined here demonstrates the importance of incorporating EHR tools such as IMO Core into the physician's workflow in order to document and track patient complexity.

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What are **HCCs?**

HCC codes lie at the heart of a payment methodology used by CMS to determine capitated payments for MA and other Medicare programs. HCC codes allow payments to be risk-adjusted based on patient complexity, leading to increased payments for high-risk patients.

The CMS methodology uses the diagnostic coding history for a patient over the previous calendar year, along with demographic data, to predict future financial utilization and risk. HCCs leverage diagnosis codes from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), which have been categorized into disease groups that are clinically and financially similar.

There are more than 9,000 ICD-10-CM codes that map to over 80 HCC categories representing costly and chronic diseases, as well as some acute conditions such as:

- Diabetes
- Chronic kidney disease
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Malignant neoplasms
- Some acute conditions (myocardial infarction, cerebrovascular accident, hip fracture)

Each HCC is assigned a Risk Adjustment Factor. The RAF reflects patient complexity with a numeric value, similar to the relative weight factor used in the inpatient diagnosis-related group (DRG) system. The RAF is multiplied by a pre-determined dollar amount to set the per-member-per-month (PMPM) capitated reimbursement for the next period of coverage. The PMPM is the payment amount a provider receives for a patient enrolled in an MA plan. The payment itself is a fixed amount based on risk-adjusted HCC methodology and is received prospective of the services provided.

Because payments are individualized, two patients within the same geographic location will have different payment rates based on calculated risk scores. While risk scores are patient specific, aggregation of the RAF across a payer-defined population can serve as a key foundation for population health management. The fixed revenue associated with the population is obtained in addition to other overall health factors of the patient population.

Timing and specificity are key in risk calculation. Every January 1, the risk-adjusted model refreshes. Additionally, the model requires physicians to evaluate and document the patient's history and chronic conditions each year. Only diagnoses which meet the conditions determine the patient's risk score.

Diagnostic combinations also affect RAF scores, and CMS has established a hierarchy to address concomitant conditions. Some diagnostic combinations, such as congestive heart failure and diabetes, generate a higher RAF score, which results in higher payments. For unrelated diagnostic combinations, individual HCC values present for each individual diagnosis. The HCCs accumulate so a patient is able to have more than one HCC attributed to them. For example, if the physician documents that a male patient suffers from heart disease, stroke, and cancer, each diagnosis maps to a separate HCC. CMS factors in all three HCCs when making a payment to the Medicare Advantage plan.

How much does specificity matter?

CMS requires that all diagnosis codes be reported to the highest level of specificity. The chart below illustrates how the ability to document with greater precision can dramatically impact payments.

Diagnosis	ICD-10-CM	HCC	Premium Bonus
Diabetes with no complications	E11.9	19	$894.40
Diabetes with diabetic neuropathic arthropathy	E11.610	18	$1094.40
Diabetes with hyperosmolar coma	E11.01	17	$1094.40
Diabetes with ESRD	E11.22, N18.6	18, 136	$1273.60
Diabetes with ESRD on chronic dialysis	E11.22, N18.6, Z99.2	18, 136, 134	$1475.20

Note: Payments are shown as examples and may differ based upon patient, region, and other factors.

Preserving revenue integrity and **clinical intent**

Preserving revenue integrity is already challenging for healthcare organizations. Changes by CMS to the risk adjustment methodology make it even harder, as the number of HCCs and affected ICD-10-CM codes can change from year to year. A change in the risk score can significantly affect the total payment received as part of the MA program.

Provider organizations face several challenges as they adopt HCC coding and documentation practices, such as:

- Insufficient documentation in the EHR
- Lack of HCC-specific analysis and prioritization in the EHR
- Poor problem list utilization
- Incorrect coding
- Disruptions to workflow and efficiency

Accurate documentation of the patient's health status using the proper ICD-10-CM codes is critical to ensuring that appropriate reimbursement occurs. CMS requires the reporting of all applicable diagnosis codes to the highest level of specificity substantiated by the medical record. However, EHRs frequently only capture the primary ICD-10-CM code, which reduces the documented complexity and impacts risk scores. The same issues also arise because providers have historically focused on documentation supporting the evaluation and management of patients, placing less emphasis on articulating diagnostic specificity – a situation that shortchanges patients and providers alike.

How can you effectively **capture HCCs in your EHR?**

Improving the process of HCC capture has wide-ranging benefits in an environment where healthcare organizations are taking on more shared patient population risk. In addition to develo-

ping organizational competency in the detailed documentation needed for risk contracts, HCCs offer a tremendous opportunity for insight into the patient population.

Real-time decision support embedded in the EHR can help providers better recognize and manage chronic conditions while improving the accuracy of their documentation. Tools like IMO Core, a point-of-care problem and diagnosis management solution, make it easy to capture and integrate essential data for HCC coding into the EHR.

By integrating a patient's existing history with IMO's terminology and problem list management suite, providers have tools to better capture, organize, and visualize clinical data. This translates to improved visibility of HCC conditions in both assessment history and problem lists, optimizing reimbursement and adding value to the problem list.

With IMO Core, intelligent prompts bring unaddressed HCCs to a provider's attention, giving them greater confidence that important details are documented. The problem list is automatically categorized into clinical specialties so it is easier to view, process, and maintain.

With IMO's clinical interface terminology, one can also see which SNOMED® and ICD-10-CM codes are mapped to a given problem, ensure that multiple ICD-10-CM codes are included where appropriate, and see which problems have associated HCCs. This capability is critical, as HCCs describe chronic problems that should be managed longitudinally. By identifying chronic conditions, providers can monitor and manage them over time, deliver proper and ongoing care, and optimize reimbursement from value-based insurance plans.

IMO Core further helps providers and health systems by ensuring that diagnostic coding is kept current. The ICD-10-CM codes associated with HCCs change each October due to ICD-10-CM regulatory updates, and the overall CMS model is also subject to annual revision. This adds yet another challenge for HCC reimbursement. However, IMO's cloud-based delivery platform ensures that providers have access and visibility to the most current diagnosis codes available.

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Case study: Improving HCC capture and reimbursement

A recent case study at a 100+ physician group in northern Illinois illustrates the value gained after developing and implementing a sound HCC strategy. The group integrated IMO Core into their leading ambulatory EHR and evaluated the impact of this solution on the identification and capture of HCC diagnoses, RAF values for those diagnoses, and risk bonuses for MA patients.

Data for 43 primary care providers treating MA patients was examined before and after implementation of IMO Core, applying reasonable controls to eliminate seasonal variation in provider behavior and fluctuations in patient and provider activity. Diagnoses falling under the CMS HCC model were totaled by month and further evaluated by provider to determine monthly trends before and after implementation.

Results supported the use of IMO Core to augment the organization's risk management strategy in several ways:

- **HCC capture increased 15%**
- **Average HCC per patient increased 16%**
- **RAF values increased 24%**
- **Monthly risk bonuses increased by $160k, or $1.9M annually**

IMO Core increased not only the number of HCCs captured but also the value of HCCs documented as measured by RAF. The table below illustrates the impact of the solution on managing HCC capture and reimbursement for the practice.

IMO Core impact on HCC capture and reimbursement

ALL CONDITIONS CODED PROPERLY	
Condition	Weight
Female	0.457
Age 76	
Stable	0.141
Angina	
Ac MI ant wall, sub EOC	0.258
Chron Ren Impair, Stage 4	0.224
Edema	0
COPD	0.346
Total RAF	1.426
PAYMENT = $9,586	

SOME CONDITIONS CODED PROPERLY	
Condition	Weight
Female	0.457
Age 76	
Stable	0.141
Angina	
Ac MI ant wall, sub EOC	0.258
Chron Ren Impair, unspec stage	0
Edema	0
History of COPD	0
Total RAF	0.856
PAYMENT = $5,334	

NO CONDITIONS CODED PROPERLY	
Condition	Weight
Female	0.457
Age 76	
Stable	
No Angina coded	
No MI coded	
No Renal Impairment coded	
Edema	
History of COPD	
Total RAF	0.457
PAYMENT = $3,409	

Make Medicare Advantage a **profitable part of your practice**

The number of Medicare Advantage plans using the risk-adjusted HCC model shows no signs of waning, and risk-adjusted models continue to influence ever-changing reimbursement structures such as ACOs. As a result, having a sound risk-adjusted program, including a plan to ensure specificity in documentation capture, is vital for providers across the country.

Accurate HCC coding creates a more complete picture of the complexity of a patient population, improves the value of the problem list, and enables better management of a patient's chronic diseases. In addition, verifying documentation specificity captured today ensures provider services remain profitable and relevant in the future.

From population health insights, to reimbursement, to individual patient care, so much hinges upon the ability to document with specificity and precision.

Contact us to learn how IMO Core can help at imohealth.com/contact-us.

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About Intelligent Medical Objects

At IMO, we are dedicated to powering care as you intended, through a platform that is intelligent, intuitive, and intentional. Used by more than 4,500 hospitals and 500,000 physicians daily, IMO's clinical interface terminology (CIT) forms the foundation for healthcare enterprise needs including effective management of EHR problem lists, accurate documentation, and the mapping of over 2.4 million clinician-friendly terms across 24 different code systems.

We offer a portfolio of products that includes terminologies and value sets that are clinically vetted, always current, and maintenance-free. This aligns to provider organizations' missions, EHR platforms' inherent power, and the evolving vision of the healthcare industry while ensuring accurate care documentation and administrative codes. So clinicians can get back to being clinicians, health systems can get reimbursed, and patients can more easily engage in their own care. As intended.